Mayfield School Health Office

High School: Janine Kilpatrick-Eccles R.N. 661-8211 Elementary School: Rebecca Lestage R.N. 661-8254

MEDICAL HISTORY UPDATE

This medical history form ***must*** be completed annually by a parent/guardian and student.
These questions are designed to determine if the student has developed (or resolved) any condition that may limit their activity in the classroom setting or gym and sports.

STUDENT_____ DATE_____GRADE_____
PHYSICIAN: _____ PHYSICIAN PHONE NUMBER: _____

During the past 12 months have you, (the student) had **any** of the following:	**YES**	**NO**
Required hospitalization or surgery?	____	____
Injury requiring medical attention; a visit to the doctor, emergency room or x-rays?	____	____
Any illnesses lasting more than one week?	____	____
****DO YOU HAVE CLEARANCE TO PARTICIPATE FROM YOUR DOCTOR?***	____	____
Do you have any joint or bone injuries? (fractures, sprains, etc.)	____	____
Do you have asthma?	____	____
Do you have diabetes?	____	____
Do you have **any allergies to medications, insects or other**?	____	____
****DO YOU HAVE OR NEED AN EPI-PEN OR INHALER?***	____	____
Have you ever had a convulsion or seizure?	____	____
Has any family member had a heart attack or died suddenly BEFORE age 50?	____	____
Have you ever had a heart murmur, or an irregular heartbeat?	____	____
Do you have heart disease or high cholesterol?	____	____
Do you have high blood pressure?	____	____
Do you have any organs missing (ex. kidney, testicle, etc.)?	____	____
****DO YOU HAVE CLEARANCE TO PARTICIPATE FROM YOUR DOCTOR?***	____	____
Do you wear any removable dental appliance?	____	____
Do you wear glasses, contacts or hearing aid?	____	____
Have you ever been dizzy or passed out from exercise?	____	____
Have you had a tetanus booster within eight years?	____	____
FEMALES ONLY: At what age did you experience your first menstruation (period)?	____	N/A

DO you take MEDICATION daily for ANY reason?	***YES***	***NO***

HAVE YOU EVER HAD A CONCUSSION OR BEEN KNOCKED OUT? YES NO

PLEASE PROVIDE INFORMATION BELOW REGARDING ANY HEAD INJURY OR HISTORY OF CONCUSSION SYNDROME.

I have received information on concussion management and have reviewed and understand this information. YES NO

A DOCTOR'S PRESCRIPTION AND WRITTEN PARENTAL PERMISSION IS NEEDED FOR ALL MEDICATIONS! This includes Epi-Pens, inhalers and ALL over the counter medications that may be needed by the student. These prescriptions may be faxed to the health office.
Clearance from a doctor's office is required if you answered yes to any of the questions listed. This may be faxed to the health office.

PLEASE EXPLAIN FULLY ALL QUESTIONS THAT WERE ANSWERED YES.

_____
_____
_____
_____
_____
_____
_____
_____

***It is the parent/guardian's responsibility to notify the transportation department of any health concerns.**

I certify, to the best of my knowledge, my answers are complete and true.
I give the health office permission to share this information with the appropriate staff for the safety of the student named on this medical update form.

_____
PARENT/GUARDIAN SIGNATURE DATE

_____
STUDENT SIGNATURE (Grades 6-12 only) DATE

Any questions or comments may be directed to the health office.

Janine Kilpatrick-Eccles R.N. High School Phone 661-8211 Fax 661-7666

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